STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155170	A. BUILDING 00 B. WING	07/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER VILLAGE MUNCIE INC	5801 W BETHEL AVE MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: July 22, 23, 24, 25, 26, 27, 2012 Facility number: 000086 Provider number: 155170 AIM number: N/A Survey team: Betty Retherford, RN, TC Ginger McNamee, RN Karen Lewis, RN Census bed type: SNF: 56 Residential: 186 Total: 242 Census payor type: Medicare: 17 Other: 225 Total: 242 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 8/01/12 by Suzanne Williams, RN	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to monitor a resident with known urinary tract infections and/or follow-up on abnormal lab test results in accordance with the resident's plan of care, for 2 of 10 residents reviewed for timely laboratory services and/or monitoring of a change in condition. (Resident #'s 53 and 62) Findings include: 1.) The clinical record for Resident #53 was reviewed on 7/24/12 at 1:35 p.m. Diagnoses for Resident #53 included, but were not limited to, history of urinary tract infections, kidney disease, urinary retention, and renal aortic aneurysm. The clinical record indicated Resident #53 had an order for a size 16 foley catheter due to a problem with urinary retention. The clinical record indicated the resident was treated with antibiotic therapy for a urinary	F0282	**Westminster Village Muncie, Inc. Plan of Correction F- 282 Services by Qualified Persons/per Care Plan (Labs)** ***1) What corrective actions(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice:*** Resident #53 clinical records were reviewed. The physician was notified and antibiotic started on July 24, 2012. Resident #62 clinical records were reviewed for labs. All labs and physician notification documented on clinical record. Although there was a brief delay in treatment (3 days) for Resident #53, it should be noted there is not any adverse effect from alleged deficient practice. ***2) How other Residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective actions(s) will be taken:*** All residents with lab orders have been reviewed for results and Physician notification. A meeting with Med Lab Services has been scheduled for August 13, 2012 at 9:30 a.m. to discuss the method of operation for communication	08/14/2012

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	tract infection in late March of 2012. A health care plan problem, dated 5/29/12, indicated Resident #53 was at risk for urinary tract infections (UTI) related to an indwelling catheter and diagnosis of urinary retention. Approaches for this problem included, but were not limited to, "Labs as ordered" and "Monitor for signs and symptoms of UTI: ...suprapubic pain, dysuria, pyuria, foul smelling urine, flank tenderness, hematuria, fever, concentrated urine, dehydration, or changes in cognitive ability and report to medical doctor as needed." A recapitulation of physician's orders, dated 7/3/12, indicated Resident #53 had an order for a urinalysis and culture and sensitivity (UA C&S) test to be done monthly to monitor for urinary tract infections. The original date of this order was 3/20/12. A UA C&S final report, dated 6/8/12, indicated Resident #53 had blood and bacteria in her urine. The report indicated the urine was positive for the organism Klebsiella Pneuomniae. The report listed 13 antibiotics to which the organism was sensitive. A notation on the report indicated it was faxed to the physician on 6/8/12.		purposes. This is in an effort to avoid the alleged deficient practice from re-occurring. ***3) What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:*** Audits will be preformed on labs and physician notification on a weekly basis. Staff nurses will be required to review and initial lab requisitions that results have been received and physician was notified within 24 hours. Culture notification to physician must be made upon receiving results. In-Servicing will occur for all Nurses by August 14, 2012. In-Services will include Lab Policy and Procedure, Documentation, Physician Notification and Order Review. A meeting with Med Lab Services has been scheduled for August 13, 2012 at 9:30 a.m. to discuss the method of operation for communication purposes. This is in an effort to avoid the alleged deficient practice from re-occurring. ***4) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality assurance program will be put into place:*** Unit Managers or designee will perform weekly audits that labs have been completed and physician notified in a timely manner to ensure quality care. The QA Committee will review the results monthly for	

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	The clinical record lacked any documentation of the fax being received by the physician on 6/8/12 or any follow up notification and/or monitoring having been completed by the nursing staff on 6/8/12, 6/9/12 or 6/10/12 related to the abnormal lab report . The clinical record indicated the physician was aware of the lab report on 6/11/12 and an order was given for Augmentin (an antibiotic) 875 milligrams twice daily for 10 days. This resulted in a time period of 3 days from the date the final lab report was received and the physician was aware of the abnormal laboratory findings and treatment was ordered. A urinalysis report, dated 7/4/12, indicated the resident's urine was positive for leukocytes. A notation on the lab report made by the physician, dated 7/5/12, indicated the physician was "awaiting C&S report." A C&S final report, dated 7/7/12, indicated the resident's urine was positive for the organism enterococcus faecalis. The report listed 4 antibiotics to which the organism was sensitive. The nursing notes lacked any monitoring of the resident related to the abnormal culture and sensitivity report from		12 months and modify the audit system as necessary to maintain compliance. ***5) All components of the systematic adjustments for notification of changes will be implemented by August 14, 2012***.	

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	7/7/12 through 7/24/12. The clinical record lacked any information related to the physician having been made aware of the abnormal C&S report prior to 7/24/12. An order, dated 7/24/12, was written on the 7/7/12 laboratory report for the resident to be given Macrobid (an antibiotic) 100 milligrams twice daily for 10 days. This resulted in a time period of 17 days from the dated the C&S report was received and the physician was notified of the abnormal results. During an interview, on 7/25/12 at 12:45 p.m., Unit Manager #1 indicated she had no information to provide related to the lack of follow-up of the lab faxed on 6/8/12. She indicated the nursing staff had failed to notify the physician of the 7/7/12 laboratory report until 7/24/12. 2.) The clinical record for Resident #62 was reviewed on 7/24/12 at 4:10 p.m. Diagnoses for the resident included, but were not limited to, chronic kidney disease, stage 2, acute kidney failure, history of deep vein thrombosis and pulmonary embolism, anemia of renal			

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	failure, hypokalemia, and chronic pancreatitis. A health care plan problem, dated 10/4/11 and last reviewed on 7/25/12, indicated the resident had a "potential for fluid volume excess, mental status changes, injury, altered nutritional status, decrease of increase in urine output, hypotension, dry mucous membranes, and infection related to renal failure." One of the approaches for this problem was "Labs as ordered and notify medical doctor of results." A health care plan problem, dated 3/16/11 and last reviewed on 7/25/12, indicated Resident #62 was at risk for increased bruising and bleeding related to Coumadin (a medication given to thin the blood) use. One of the approaches for this problem was "Lab levels as ordered, notify physician of results." The resident had physician's orders, signed 6/5/12, for a CBC (complete blood count), CMP (complete metabolic profile), and PT/INR (prothrombin time and international ratio) (a test done to monitor the thinness of the blood) to be done twice weekly on Mondays and Thursdays.			

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	The clinical record contained CBC, CMP, and PT/INR laboratory reports dated 7/16/12 and 7/23/12. The clinical record lacked any report for these tests having been sent on Thursday 7/19/12. The clinical record lacked any information related to the nursing staff following up on the missing laboratory report. The clinical record indicated the resident's Coumadin medication had been changed on 7/10, 7/12, and 7/17/12 based on the PT/INR reports. The last order change, dated 7/17/12, indicated the resident was to receive Coumadin 1.5 milligrams every other day alternating with 2 milligrams on opposite days. Laboratory reports for the above noted tests, dated 7/23/12, contained a comparative section on the reports which included results from the labs drawn on 7/19/12. The results for 7/19/12 indicated the resident's hemoglobin and hematocrit (tests done to monitor anemia), calcium level, protein level, and albumin level were all "low". The resident's PT/INR report indicated the levels were "high". During an interview on 7/25/12 at 2:10 p.m., Unit Manager #1 indicated			

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	she was unable to find any information related to the 7/19/12 lab reports having been received by the facility prior to the comparative section information noted on the 7/23/12 lab report. She indicated she had no information to provide related to the physician having been made aware of the abnormal 7/19/12 lab results until the blood test reports for Monday 7/23/12 were received which contained the comparative information. 3.) The undated procedure for "Routine laboratory orders" was provided by the Assistant Administrator on 7/27/12 at 11:05 a.m. The procedure indicated a copy of the report [laboratory] will be sent to the resident's physician and one to the Health Center for inclusion in the resident's medical record. This copy is to [be] placed on the chart. If the lab results are abnormal, contact the physician's office to verify receipt of the results. 4.) The undated procedure for "Condition Change, of the Resident (Observing, Recording And Reporting" was provided by the Assistant Administrator on 7/27/12 at 11:05 a.m. The procedure indicated it was the basic responsibility of the licensed nurse to document the date			

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	and time the condition change was identified. The procedure indicated an observation of the resident should be documented at least every shift until the condition is stable by the licensed nurse. 3.1-35(g)(2)			

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure a resident was given the accurate insulin sliding scale coverage as ordered for 1 of 3 residents reviewed for accuracy of insulin sliding scale coverage. (Resident #50) Findings include: 1.) The clinical record for Resident #50 was reviewed on 7/27/11 at 10:06 a.m. Diagnosis for Resident #50 included, but were not limited to, diabetes mellitus type 2, congestive heart failure, and dementia. A health care plan problem, dated 12/20/10, indicated the resident had a diagnosis of diabetes and was at risk for complications associated with the diagnosis. Two of the approaches for this problem included, but were not limited to, administer medications as	F0309	**Westminster Village Muncie, Inc. Plan of Correction F- 309 Provide Care/Services for Highest Wellbeing (insulin sliding scale)** ***1) What corrective actions(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice:*** Resident #50 clinical records were reviewed, physician notified with no negative outcome. ***2) How other Residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective actions(s) will be taken:*** All insulin dependent Residents' clinical records have been reviewed for accuracy. Documentation of all residents with sliding scales have been reviewed for accuracy and were found to be in compliance at this time. ***3) What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:*** Unit Managers or designees will monitor all	08/14/2012

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	ordered and monitor blood glucose as ordered. Resident #50 had physician's orders for the following, A. Monitor blood sugar results 4 times daily at 7:00 a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m. The original date of this order was 7/5/11. B. Administer Lantus insulin 10 units subcutaneously at bedtime. The original date of this order was 9/7/11. C. Administer Humalog sliding scale insulin according to blood sugar results as listed below, 141 - 180 = 1 unit 181 - 220 = 2 units 221 - 260 = 4 units 261 - 300 = 6 units 301 - 340 = 7 units 341 - 380 = 8 units 381 - 420 = 9 units 421 - 460 = 10 units greater than 460 = 12 units give 1/2 the coverage at bedtime and round up to the nearest whole The original date of this order was 7/5/11. Review of the May 2012 "Monthly		Residents with sliding scale insulin coverage to ensure the alleged deficient practice does not reoccur. In-Services will occur for all Nurses by August 14, 2012. In-Services will include Lab Policy and Procedures, Documentation, Physician Notification and Order Review. ***4) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality assurance program will be put into place:*** Unit Managers or designees will monitor all Residents with sliding scale insulin, coverage weekly for 3 months and then monthly for 9 months to ensure quality care. The Quality Assurance Committee will review the results monthly for 12 months and modify the audit system as necessary to maintain compliance. ***5) All components of the systematic adjustments for notification of changes will be implemented by August 14, 2012***.	

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	Glucometer Log" for Resident #50 indicated the incorrect dose of insulin was documented as having been given on the following dates and times, May 8, 4:00 p.m., blood sugar result was 156, 2 units of insulin was documented as having been given. The resident should have received 1 unit. May 14, 8:00 p.m., blood sugar result was 147, no insulin was documented as having been given. the resident should have received 1 unit. May 15, 4:00 p.m., blood sugar result was 155, 2 units insulin was documented as having been given. The resident should have received 1 unit. May 19, 8:00 p.m., blood sugar result was 142, no insulin was documented as having been given. The resident should have received 1 unit. May 23, 11:00 a.m., blood sugar result was 213, 1 unit of insulin was documented as having been given. The resident should have received 2 units. May 30, 4:00 p.m., blood sugar result			

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	was 259, 2 units of insulin was documented as having been given. The resident should have received 4 units. June 15, 8:00 p.m., blood sugar result was 164, no insulin was documented as having been given. The resident should have received 1 unit. June 28, 11:00 a.m., blood sugar result was 220, 4 units of insulin was documented as having been given. The resident should have received 2 units. July 1, 8:00 p.m., no blood sugar result was was documented, no insulin was documented as having been given. July 21, 4:00 p.m., blood sugar result was documented as 186 and 244, 4 units of insulin was documented as having been given. The resident should have received 2 units if blood sugar result was 186. July 23, 8:00 p.m., blood sugar result was 397, 4 units of insulin was documented as having been given. The resident should have received 5 units.			

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	July 26, 4:00 p.m., blood sugar result was 180, no insulin was documented as having been given. The resident should have received 1 unit. During an interview with the Unit Manager #3 on 7/27/12 at 12:20 p.m. additional information was requested related to the inaccurate sliding scale coverage having been documented as given on the dates and time noted above. The facility failed to provide any additional information as of exit on 7/27/12. The undated "Blood Sugar Monitoring" policy was provided by the Assistant Administrator on 11/27/12 at 1:30 p.m. The procedure indicated "...1. Check physician's order for blood sugar testing....3. Follow manufacturer's directions for the equipment used in your facility....If insulin is ordered based on a sliding scale document the type and amount of insulin administered and the site of injection...." 3.1-37(a)			

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F0315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on record review and interview, the facility failed to monitor a resident with known urinary tract infections and notify the physician of abnormal culture and sensitivity reports in a timely manner to ensure prompt treatment for 1 of 3 residents reviewed of the 4 who met the criteria for urinary catheter use. (Resident # 53) Findings include: 1.) The clinical record for Resident #53 was reviewed on 7/24/12 at 1:35 p.m. Diagnoses for Resident #53 included, but were not limited to, history of urinary tract infections, kidney disease, urinary retention, and renal aortic aneurysm.	F0315	**Westminster Village Muncie, Inc. Plan of Correction F- 315 No Catheter, Prevent UTI, Restore Bladder** ***1) What corrective actions(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice:*** Resident #53 clinical records were reviewed, physician notified and antibiotics were started on July 24, 2012. It should be noted that Nursing Staff have beenreminded during in-service meetings that although the in-house Medical Director makes rounds on a weekly basis, he still must be notified as we wouldwith a Primary Care Physician. The Medical Director Physician signature folders that are kept on each unit does not alleviate pertinent phone calls andfaxed information related to abnormal labs, change of condition, etc. ***2) How other Residents having the potential to be affected by the same***	08/14/2012

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	155170	A. BUILDING 00 B. WING	07/27/2012

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	The clinical record indicated Resident #53 had an order for a size 16 foley catheter due to a problem with urinary retention. The clinical record indicated the resident was treated with antibiotic therapy for a urinary tract infection in late March of 2012. A health care plan problem, dated 5/29/12, indicated Resident #53 was at risk for urinary tract infections (UTI) related to an indwelling catheter and diagnosis of urinary retention. Approaches for this problem included, but were not limited to, "Labs as ordered" and "Monitor for signs and symptoms of UTI: ...suprapubic pain, dysuria, pyuria, foul smelling urine, flank tenderness, hematuria, fever, concentrated urine, dehydration, or changes in cognitive ability and report to medical doctor as needed." A recapitulation of physician's orders, dated 7/3/12, indicated Resident #53 had an order for a urinalysis and culture and sensitivity (UA C&S) test to be done monthly to monitor for urinary tract infections. The original date of this order was 3/20/12. A UA C&S final report, dated 6/8/12, indicated Resident #53 had blood and bacteria in her urine. The report indicated the urine was positive for		***alleged deficient practice will be identified and what corrective actions(s) will be taken:*** All Residents' clinical records have been reviewed, physician notified for lab results and change in condition. ***3) What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:*** Audits will be performed on labs and physician notification on a weekly basis for 12 months. Protocol for UTI was updated to include checking shift onset of systems until lab results have been obtained and/or treatment completed. In-Services will occur for all Nurses by August 14, 2012. In-Services will include Lab Policy and Procedures, Documentation, Physician Notification, Protocol Update and Order Review. ***4) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality assurance program will be put into place:*** Unit Managers or designees will perform weekly audits that labs/protocol has been completed and physician notified in a timely manner to ensure quality care. The Quality Assurance Committee will review the results monthly for 12 months and modify the audit system as necessary to maintain compliance. ***5) All components***	

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	the organism Klebsiella Pneuomniae. The report listed 13 antibiotics to which the organism was sensitive. A notation on the report indicated it was faxed to the physician on 6/8/12. The clinical record lacked any documentation of the fax being received by the physician on 6/8/12 or any follow up notification and/or monitoring having been completed by the nursing staff on 6/8/12, 6/9/12 or 6/10/12 related to the abnormal lab report . The clinical record indicated the physician was aware of the lab report on 6/11/12 and an order was given for Augmentin (an antibiotic) 875 milligrams twice daily for 10 days. This resulted in a time period of 3 days from the date the final lab report was received and the physician was aware of the abnormal laboratory findings and treatment was ordered. A urinalysis report, dated 7/4/12, indicated the resident's urine was positive for leukocytes. A notation on the lab report made by the physician, dated 7/5/12, indicated the physician was "awaiting C&S report." A C&S final report, dated 7/7/12, indicated the resident's urine was positive for the organism		***of the systematic adjustments for notification of changes will be implemented by August 14, 2012***.	

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	enterococcus faecalis. The report listed 4 antibiotics to which the organism was sensitive. The nursing notes lacked any monitoring of the resident related to the abnormal culture and sensitivity report from 7/7/12 through 7/24/12. The clinical record lacked any information related to the physician having been made aware of the abnormal C&S report prior to 7/24/12. An order, dated 7/24/12, was handwritten by the physician on the 7/7/12 laboratory report for the resident to be given Macrobid (an antibiotic) 100 milligrams twice daily for 10 days. This resulted in a time period of 17 days from the dated the C&S report was received and the physician was notified of the abnormal results. During an interview, on 7/25/12 at 12:45 p.m., Unit Manager #1 indicated she had no information to provide related to the lack of follow-up for the lab faxed on 6/8/12. She indicated the nursing staff had failed to notify the physician of the 7/7/12 laboratory report until 7/24/12. 2.) The undated procedure for "Routine laboratory orders" was provided by the Assistant			

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	Administrator on 7/27/12 at 11:05 a.m. The procedure indicated a copy of the report [laboratory] will be sent to the resident's physician and one to the Health Center for inclusion in the resident's medical record. This copy is to [be] placed on the chart. If the lab results are abnormal, contact the physician's office to verify receipt of the results. 3.) The undated procedure for "Condition Change, of the Resident (Observing, Recording And Reporting" was provided by the Assistant Administrator on 7/27/12 at 11:05 a.m. The procedure indicated it was the basic responsibility of the licensed nurse to document the date and time the condition change was identified. The procedure indicated an observation of the resident should be documented at least every shift until the condition is stable by the licensed nurse. 3.1-41(a)(2)			

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F0428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.			
	Based on record review and interview, the Consultant Pharmacist failed to identify physician orders with the potential to exceed the daily maximum recommended dose of a drug for 2 of 10 residents reviewed for unnecessary medications. (Resident #16 and #50) Findings include: 1). The clinical record for Resident #16 was reviewed on 7/25/12 at 1:26 p.m. Diagnoses for Resident #16 included, but were not limited to, congestive heart failure, bipolar disorder, and pain. Current physician's orders for Resident #16 included, but were not limited to, the following orders for pain: a). Hydrocodone (a pain medication	F0428	**Westminster Village Muncie, Inc. Plan of Correction F- 428 Drug Regimen Review, Report Irregular, Act On** ***1) What corrective actions(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice:*** Residents' #16 and #20 clinical records werereviewed. A. Physician was notified of potential concern. B. Warning was attached to acetaminophen/acetaminophen combo order not to exceed 4 grams of acetaminophen per 24 hour period. C. Neither resident had more than 4 grams of acetaminophen in a 24 hour period resulting in no detrimental effect. ***2) How other Residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective actions(s) will be taken:*** As of August 10, 2012, all residents having the potential for exceeding the maximum daily	08/14/2012

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	that contains Tylenol) 5/325 milligrams (mg) 1 tablet 4 times a day (original order date 2/28/12) b). Tylenol (a pain medication) 325 mg tablet 2 tablets (650 mg) 3 times a day as needed for pain (original order date 1/6/09) c). Tylenol (a pain medication) 325 mg tablet 2 tablets (650 mg) 3 times a day as needed for an elevated temperature (original order date 1/6/09) d). Hydrocodone (a pain medication that contains Tylenol) 5/325 milligrams (mg) 1 tablet 4 times a day as needed for pain (original order date 2/28/12) The clinical record indicated the pharmacist reviewed the physician's orders on 6/19/12 and 7/13/12. No recommendations were made related to the maximum amount of Tylenol that could safely be given in a 24 hour period. During an interview with Unit Manager #2 on 7/26/12 at 9:54 a.m., additional information was requested related to the pharmacy consultant's report and lack of recommendations related to the Tylenol and the Hydrocodone		dose of acetaminophen (4 grams in a 24 hour period) have been re-reviewed to prevent alleged deficient practice. A written pharmacist recommendation has been made to the physician on any resident having the potential for the alleged deficient practice. ***3) What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:*** Staff in-serviced regarding physician orders and maximum dosage allowed for acetaminophen to avoid any further recurrence of the alleged deficient practice. ***4) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality assurance program will be put into place:*** Unit Managers will monitor doses of acetaminophen given for those residents with the potential for exceeding the maximum dose of acetaminophen on a weekly basis and report to the Director of Nursing. Pharmacy Consultant will continue to review all acetaminophen orders of doses on a monthly basis. If any resident is exceeding 4 grams per day, the physician and Director of Nursing will be alerted. The Quality Assurance Committee will review the results monthly for 12 months and modify the audit system as necessary to maintain	

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	orders following the 6/19/12 and 7/13/12 pharmacy reviews. During an interview with Unit Manager #2 on 7/26/12 at 11:00 a.m., she indicated there were no recommendations from the 6/19/12 and 7/13/12 pharmacy reviews. 2.) The clinical record for Resident #50 was reviewed on 7/27/11 at 10:06 a.m. Diagnoses for Resident #50 included, but were not limited to, diabetes mellitus type 2, congestive heart failure, and dementia. Current physician's orders for Resident #50 included, but were not limited to, the following orders for pain: a). Tylenol (a pain medication) 325 milligrams (mg) tablet 2 tablets (650 mg) daily at bedtime (original order date 3/26/12) b). Hydrocodone (a pain medication that contains Tylenol) 5/325 mg 1 tablet 3 times a day (original order date 5/9/12) c). Tylenol (a pain medication) 325 mg tablet 2 tablets (650 mg) every 4		compliance. ***5) All components of the systematic adjustments for notification of changes will be implemented by August 14, 2012***.	

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	hours as needed for pain (original order date 1/4/12) d). Tylenol (a pain medication) 325 mg tablet 2 tablets (650 mg) every 4 hours as needed for an elevated temperature (original order date 1/4/12) The clinical record indicated the pharmacist reviewed the physician's orders on 6/29/12 and 7/23/12. No recommendations were made related to the maximum amount of Tylenol that could safely be given in a 24 hour period. During an interview with the Assistant Administrator on 7/27/12 at 11:54 a.m., additional information was requested related to the pharmacy consultant's report and lack of recommendations related to the Tylenol and the Hydrocodone orders following the 6/19/12 and 7/13/12 pharmacy reviews. The facility failed to provide any additional information as of exit on 7/27/12. 3.) The Nursing Drug Handbook 2010 indicates the maximum daily dose of Tylenol (acetaminophen) should not exceed 4000 milligrams			

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	per day. 3.1-25(h)			

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F0502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on record review and interview, the facility failed to ensure the quality and timeliness of laboratory services for 2 of 10 residents reviewed for laboratory services. (Resident #'s 62 and 83) Findings include: 1.) The clinical record for Resident #62 was reviewed on 7/24/12 at 4:10 p.m. Diagnoses for the resident included, but were not limited to, chronic kidney disease, stage 2, acute kidney failure, history of deep vein thrombosis and pulmonary embolism, anemia of renal failure, hypokalemia, and chronic pancreatitis. The resident had physician's orders, signed 6/5/12, for a CBC (complete blood count), CMP (complete metabolic profile), and PT/INR (prothrombin time and international ratio) (a test done to monitor the thinness of the blood) to be done twice weekly on Mondays and	F0502	**Westminster Village Muncie, Inc. Plan of Correction F- 502 Administration (Labs)** ***1) What corrective actions(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice:*** Residents' #62 and #83 clinical records have been reviewed and physician notified of the noted concern.A meeting with Med Lab Services has been scheduled for August 13, 2012 at 9:30 a.m. to discuss the method of operation for communication purposes. This is in an effort to avoid the alleged deficient practice from re-occurring. ***2) How other Residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective actions(s) will be taken:*** All residents with lab orders have been reviewed for results and physician notification. This action was completed by August 10, 2012. A meeting with Med Lab Services has been scheduled for August 13, 2012 at 9:30 a.m. to discuss the method of operation for communication purposes. This is in an effort to avoid the alleged deficient	08/14/2012

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	Thursdays. The clinical record contained CBC, CMP, and PT/INR laboratory reports dated 7/16/12 and 7/23/12. The clinical record lacked any report for these tests having been sent on Thursday 7/19/12. Laboratory reports for the above noted tests, dated 7/23/12, contained a comparative section on the reports which included results from the labs drawn on 7/19/12. The results for 7/19/12 indicated the resident's hemoglobin and hematocrit (tests done to monitor anemia), calcium level, protein level, and albumin level were all "low". The resident's PT/INR report indicated the levels were "high". During an interview on 7/25/12 at 2:10 p.m., Unit Manager #1 indicated she had no information to provide related to any report for the 7/19/12 labs having been received by the facility prior to those results being listed in the comparative section on the 7/23/12 lab report. 2.) The clinical record for Resident		practice from re-occurring. ***3) What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:*** Audits will be performed on labs and physician notification on a weekly basis. Staff nurses will be required to review and initial lab requisitions that lab results have been received and physician was notified within 24 hours. Culture notifications to physician upon receiving results. In-Servicing will occur for all Nurses by August 14, 2012. In-Services will include Lab Policy and Procedure, Documentation, Physician Notification and Order Review. ***4) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality assurance program will be put into place:*** Unit Managers or designee will perform weekly audits that labs have been completed and physician notified in a timely manner to ensure quality care. The QA Committee will review the results monthly for 12 months and modify the audit system as necessary to maintain compliance. ***5) All components of the systematic adjustments for notification of changes will be implemented by August 14, 2012***.	

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	#83 was reviewed on 7/24/12 at 1:29 p.m. Diagnoses for Resident #83 included, but were not limited to, hypertension, arthritis, depression and anxiety. A physician's order dated 7/10/12, indicated Resident #83 was to have a complete blood count and comprehensive metabolic profile (blood tests) on 7/12/12. The clinical record lacked any results related to a complete blood count blood test on 7/12/12. During an interview with Unit Manager #2 on 7/25/12 at 12:55 p.m., additional information was requested related to the missing complete blood count blood test results. During an interview with Unit Manager #2 on 7/25/12 at 2:08 p.m., she indicated the complete blood count blood test had been ordered, but the laboratory did not draw the blood test. 3.) The 5/98, revised procedure for "Laboratory, radiology, and other diagnostic services" was provided on 7/27/12 at 11:05 a.m., by the Assistant Administrator. The procedure indicated the facility would			

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	provide or obtain laboratory services to meet the needs of its residents. The facility would be responsible for the quality and timeliness of the services. The procedure indicated the laboratory will be responsible for reporting the results of such tests to the attending physician and a written copy was to be sent to the facility to be placed in the resident records. 3.1-49(a)			

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F0505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. Based on record review and interview, the facility failed to ensure the physician was notified of abnormal urine culture and sensitivity reports in a timely manner for 1 of 3 residents reviewed of the 4 who met the criteria for urinary catheter use. (Resident # 53) Findings include: 1.) The clinical record for Resident #53 was reviewed on 7/24/12 at 1:35 p.m. Diagnoses for Resident #53 included, but were not limited to, history of urinary tract infections, kidney disease, urinary retention, and renal aortic aneurysm. The clinical record indicated Resident #53 had an order for a size 16 foley catheter due to a problem with urinary retention. A recapitulation of physician's orders, dated 7/3/12, indicated Resident #53 had an order for a urinalysis and culture and sensitivity (UA C&S) test to be done monthly to monitor for	F0505	**Westminster Village Muncie, Inc. Plan of Correction F- 505 Promptly Notify Physician of Lab Results** ***1) What corrective actions(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice:*** Resident #53 clinical records were reviewed, physician notified and antibiotic started on July 24, 2012. Resident #62 clinical records were reviewed for labs. All labs and physician notification on clinical record. Reminder discussed with Nursing staff in-service meetings by August 14, 2012, that although in-house Medical Director makes weekly routine rounds and has signature folders on each unit, it is important to place a call to him as any other primary care physician in the contact process and reporting. ***2) How other Residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective actions(s) will be taken:*** All residents' clinical records with lab orders have been reviewed for results and physician notification. A meeting with Med Lab Services has been scheduled for August 13, 2012 at 9:30 a.m.	08/14/2012

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	155170	A. BUILDING 00 B. WING	07/27/2012

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	urinary tract infections. The original date of this order was 3/20/12. A UA C&S final report, dated 6/8/12, indicated Resident #53 had blood and bacteria in her urine. The report indicated the urine was positive for the organism Klebsiella Pneuomniae. The report listed 13 antibiotics to which the organism was sensitive. A notation on the report indicated it was faxed to the physician on 6/8/12. The clinical record lacked any documentation of the fax being received by the physician on 6/8/12 or any follow up notification having been completed by the nursing staff on 6/8/12, 6/9/12 or 6/10/12 related to the abnormal lab report . The clinical record indicated the physician was aware of the lab report on 6/11/12 and an order was given for Augmentin (an antibiotic) 875 milligrams twice daily for 10 days. This resulted in a time period of 3 days from the date the final lab report was received and the physician was aware of the abnormal laboratory findings and treatment was ordered. A urinalysis report, dated 7/4/12, indicated the resident's urine was positive for leukocytes. A notation on		to discuss the method of operation for communication purposes. This is in an effort to avoid the alleged deficient practice from re-occurring. ***3) What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:*** Audits will be performed on labs and physician notification on a weekly basis. Staff nurses will be required to review and initial lab requisitions that results have been received and physician was notified within 24 hours. Culture notification to physician upon receiving results. In-Servicing will occur for all Nurses by August 14, 2012. In-Services will include Lab Policy and Procedure, Documentation, Physician Notification and Order Review. ***4) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality assurance program will be put into place:*** Unit Managers or designee will perform weekly audits that labs have been completed and physician notified in a timely manner to ensure quality care. The QA Committee will review the results monthly for 12 months and modify the audit system as necessary to maintain compliance. ***5) All components of the systematic adjustments for notification of changes will***	

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	the lab report made by the physician, dated 7/5/12, indicated the physician was "awaiting C&S report." A C&S final report, dated 7/7/12, indicated the resident's urine was positive for the organism enterococcus faecalis. The report listed 4 antibiotics to which the organism was sensitive. The clinical record lacked any information related to the physician having been made aware of the abnormal C&S report prior to 7/24/12. An order, dated 7/24/12, was written on the 7/7/12 laboratory report for the resident to be given Macrobid (an antibiotic) 100 milligrams twice daily for 10 days. This resulted in a time period of 17 days from the dated the C&S report was received and the physician was notified of the abnormal results. During an interview, on 7/25/12 at 12:45 p.m., Unit Manager #1 indicated she had no information to provide related to the lack of follow-up of the lab faxed on 6/8/12. She indicated the nursing staff had failed to notify the physician of the 7/7/12 laboratory report until 7/24/12.		***be implemented by August 14, 2012***.	

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	The undated procedure for "Routine laboratory orders" was provided by the Assistant Administrator on 7/27/12 at 11:05 a.m. The procedure indicated a copy of the report [laboratory] will be sent to the resident's physician and one to the Health Center for inclusion in the resident's medical record. This copy is to [be] placed on the chart. If the lab results are abnormal, contact the physician's office to verify receipt of the results. 3.1-49(f)(2)	F0505	**Westminster Village Muncie, Inc. Plan of Correction F- 505 Promptly Notify Physician of Lab Results** ***1) What corrective actions(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice:*** Resident #53 clinical records were reviewed, physician notified and antibiotic started on July 24, 2012. Resident #62 clinical records were reviewed for labs. All labs and physician notification on clinical record. Reminder discussed with Nursing staff in-service meetings by August 14, 2012, that although in-house Medical Director makes weekly routine rounds and has signature folders on each unit, it is important to place a call to him as any other primary care physician in the contact process and reporting. ***2) How other Residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective actions(s) will be taken:*** All residents' clinical records with lab orders have been reviewed for results and physician notification. A meeting with Med Lab Services has been scheduled for August 13, 2012 at 9:30 a.m. to discuss the method of operation for communication purposes. This is in an effort to avoid the alleged deficient practice from re-occurring. ***3)***	08/14/2012

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			What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur: Audits will be performed on labs and physician notification on a weekly basis. Staff nurses will be required to review and initial lab requisitions that results have been received and physician was notified within 24 hours. Culture notification to physician upon receiving results. In-Servicing will occur for all Nurses by August 14, 2012. In-Services will include Lab Policy and Procedure, Documentation, Physician Notification and Order Review. ***4) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality assurance program will be put into place:*** Unit Managers or designee will perform weekly audits that labs have been completed and physician notified in a timely manner to ensure quality care. The QA Committee will review the results monthly for 12 months and modify the audit system as necessary to maintain compliance. ***5) All components of the systematic adjustments for notification of changes will be implemented by August 14, 2012***.	

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure hospice nursing documentation (Resident #16) and weekly weights (Resident #83) were documented in the clinical record for 1 of 1 resident reviewed for hospice services and for 1 of 3 residents reviewed of the 14 residents who met the criteria for nutritional services. Findings include: 1.) The clinical record for Resident #16 was reviewed on 3/7/12 at 2:11 p.m. Diagnoses for Resident #16 included, but were not limited to, congestive heart failure, bipolar disorder, and pain.	F0514	**Westminster Village Muncie, Inc. Plan of Correction F- 514 Records - Complete/Accurate/Accessible (Hospice and weekly weights)** ***1) What corrective actions(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice:*** Resident #16 clinical records were reviewed. Hospice was notified. All notes obtained from Hospice Services are on clinical record. Resident #83 clinical records were reviewed. The weights have been recorded in the clinical record as a late entry. ***2) How other Residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective actions(s) will be taken:*** All Residents' clinical records on Hospice with services	08/14/2012

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	The clinical record for Resident #16 lacked any documentation for individual hospice nursing visits. During an interview with Unit Manager #2 on 7/26/12 at 2:45 p.m., additional information was requested related to the documentation of hospice nursing visits. During an interview with Unit Manager #2 on 7/27/12 at 8:15 a.m., she indicated there was no documentation of the hospice nursing visits in the resident's chart. 2.) The clinical record for Resident #83 was reviewed on 7/24/12 at 1:29 p.m. Diagnoses for Resident #83 included, but were not limited to, hypertension, arthritis, depression and anxiety. The clinical record for Resident #83 lacked any documentation of weekly weights for 6/13/12 and 6/22/12. During an interview with Unit Manager #2 on 7/25/12 at 2:08 p.m., additional information was requested related to the weekly weights for 6/13/12 and 6/22/12. During an interview with Unit Manager		have been reviewed for appropriate documentation. Documentation is on the chart in effort to provide continuity of care from all providers. ***3) What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:*** Designee will report to Unit Managers any weekly weights not obtained. Unit Managers will audit weekly that weights were obtained and documented in the clinical records through computer entry reports. ***4) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality assurance program will be put into place:*** Unit Manager will monitor on a weekly basis. The Quality Assurance Committee will review the results monthly for 12 months and modify the audit system as necessary to maintain compliance. ***5) All components of the systematic adjustments for notification of changes will be implemented by August 14, 2012***.	

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	#2 on 7/26/12 at 10:55 a.m., she indicated the weekly weights for 6/13/12 and 6/22/12 were not documented in the resident's clinical record, only on the 24 hour report sheets. She indicated the 24 hour report sheets were not part of the resident's clinical record. 3.) The revised 5/98, "Clinical records policy" was provided by the Assistant Administrator on 7/27/12 at 11:05 a.m., and indicated the records must be complete and accurately documented. 3.1-50(a)(1) 3.1-50(a)(2)			